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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: March 30, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Electromyography (EMG) of the left upper extremity (95885, 95905) and nerve conduction studies (NCS) of the left upper extremity (95907, 95908).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒**Upheld** **(Agree)**

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The requested electromyography (EMG) of the left upper extremity (95885, 95905) and nerve conduction studies (NCS) of the left upper extremity (95907, 95908) are not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported a work-related injury on xx/xx/xx. The patient's mechanism of injury was stepping on a shoelace and tripping forward, landing on her face. Her diagnoses included open wound to face. On 2/4/15 the patient had magnetic resonance imaging (MRI) of the cervical spine performed with results that indicated reversal of normal cervical lordosis with a 1.4 mm anterior subluxation of C4 on C5; anterior interbody fusions of C5-6 and C6-7; facet hypertrophic changes of C2-3 with minor left and moderate right neural foraminal narrowing;

facet hypertrophic changes at C3-4 with minor right neural foraminal narrowing, disc bulge and facet hypertrophic changes at C4-5, and minor central canal with minor bilateral neural foraminal narrowing; postoperative changes with uncovertebral spurring and facet hypertrophic changes at C5-6 and minor narrowing of the central canal with mild to moderate left neural foraminal narrowing; postoperative changes with uncovertebral spurring and facet hypertrophic changes at C6-7 and minor narrowing of the central canal with moderate bilateral neural foraminal narrowing; and bulging annulus at C7-T1. The office note dated 2/16/15 documented the patient was recovering from left rotator cuff surgery when she fell. She has received injections, medication, and physical therapy. The patient indicated she has had x-rays, MRI scanning, and electromyography (EMG)/nerve condudction velocity (NCV) testing performed within the last six months. On physical examination, there was no significant spasm or tenderness in the sternal mastoid muscles, no anterior cervical tenderness, positive tenderness in both trapezius muscles (left worse than right), and left medial scapular pain. The patient's range of motion of the cervical spine was measured in flexion at 10 degrees and rotation left and right 20 degrees. Manual motor testing suggested no deficit except for the intrinsic muscles in the left hand, which were atrophic and grade 4-. At that time the provider recommended EMG of the left upper extremity and nerve conduction studies (NCS) of the left upper extermity.

The URA denial letter dated 3/9/15 indicates that it is unclear why a repeat EMG study is warranted and there was no clinical rational provided for an NCV in this patient.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) state that an EMG may be helpful for patients with dull crush phenomenon, in particular, when there is evidence of possible metabolic pathology, such as neuropathy secondary to diabetes or thyroid disease, or evidence of peripheral compression, such as carpal tunnel syndrome. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy. The MRI findings of 2/4/15 indicate neural foraminal narrowing bilaterally at C4-5, C5-6, and C6-7. The patient's muscle strength is a 4- to 5 in the shoulders and upper extremities, although range of motion is restricted. The patient has failed conservative care. The patient indicated she received an EMG/NCV within the last six months; however this documentation was not included for review. In this case, MRI findings indicated neural foraminal narrowing, thus the request for an EMG of the left upper extremity is not medically necessary as there is no indication for a repeat EMG at this time.

In addition, the Official Disability Guidelines state NCS is not recommended to demonstrate radiculopathy, if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic process if other diagnoses may be likely based on a clinical exam. In this case, the MRI findings indicated neural foraminal narrowing and there is no indication for a repeat EMG, therefore, an NCS is not medically necessary. As such, the requested services are not medically necessary for treatment of the patient's condition. All told, the medical necessity for EMG of the left upper extremity (95885,

95905) and NCS of the left upper extremity (95907, 95908) has not been established. Based on the clinical information received and the ODG guidelines, the current request cannot be determined as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☐ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**